

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No.

Primary Registration District No.

Registrar's No.

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

FILE NO. 006 64 318

1003

0050996  
1067

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF
1						
2 325						
3						
4 0						
5 9						
6						
7 9						
8 2						
9						
10						
11						
12 92-3						
13						
91	SHOULD READ	ITEM NO.				

USE BLACK INK  
OR  
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>ST. LOUIS</u>		c. CITY OR TOWN <u>ST. LOUIS</u>	
c. FULL NAME OF (If NOT in hospital, give location) <u>D.O.A. CITY HOSPITAL</u>		d. STREET ADDRESS (If outside, give location) <u>821 Chestnut</u>	
3. NAME OF DECEASED (Type or print) <u>CHARLES FREDERICK</u>		4. DATE OF DEATH <u>12-30-63</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>UNK.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNK.</u>		11. BIRTHPLACE (City and state or country) <u>Unknown</u>	
13a. FATHER'S NAME <u>UNK.</u>		14. NAME OF HUSBAND OR WIFE <u>UNK.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNK.</u>		17. INFORMANT <u>Helen L. Taylor-Coroner-1300 Clark</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>w.m.a.</u> DUE TO (c) <u>4201</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20c. TIME OF INJURY Hour <u>7</u> a.m. <u>7</u> p.m.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>9:57 a.m.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.		20f. CITY, TOWN, OR LOCATION <u>St. Louis, Mo.</u>	
22a. SIGNATURE (Degree or title) <u>Helen L. Taylor Coroner</u>		22b. ADDRESS <u>1300 Clark Ave</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>1-31-64</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>	
23b. DATE <u>1-31-64</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>	
24. FUNERAL DIRECTOR <u>MO. ANATOMICAL BOARD, 1402 S. GRAND</u>		25. DATE RECD. BY LOCAL REG. <u>JAN 30 1964</u>	
		26. REGISTRAR'S SIGNATURE <u>Joan Smith, M.D.</u>	

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.